EXHIBIT C

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

Master File No. 2:12-MD-02327 MDL 2327

IN RE: ETHICON, INC., PELVIC REPAIR SYSTEM PRODUCTS LIABILITY LITIGATION

JANET WEBB,

Plaintiff,

v.

ETHICON, INC., ET AL.,

Defendants.

JOSEPH R. GOODWIN
U.S. DISTRICT JUDGE

CIVIL ACTION NO.
2:13-cv-04517

Baltimore, Maryland
Thursday, July 14, 2016

Deposition of:

HARRY W. JOHNSON, JR., M.D. the witness, was called for examination by counsel for the Plaintiff, pursuant to notice, commencing at 11:05 a.m., at the Kimpton Hotel Monaco Baltimore Inner Harbor, 2 North Charles Street, Baltimore, Maryland 21201, before a Notary Public in and for the State of Maryland, when were present on behalf of the respective parties:

A P P E A R A N C E S

ON BEHALF OF THE PLAINTIFF:

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C O N T E N T S

E X H I B I T S

P R O C E E D I N G S

Whereupon,

HARRY W. JOHNSON, JR., M.D.

a Witness, called for examination by counsel for the Plaintiff, having first been duly sworn, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR PLAINTIFF

BY MR. CRONE:

Q. Dr. Johnson, could you state and spell your name for the record.

A. Harry Wallace Johnson, Jr. That's Harry, H-a-r-r-y, W-a-l-l-a-c-e, J-o-h-n-s-o-n, J-r.

Q. I know you've been deposed before.

A. Yes.

Q. And you understand the ground rules for a deposition?

A. I do.

Q. I will just, again, repeat that any question you don't understand please just ask me to clarify.

A. Okay.

Q. Okay. So I will hand you what we'll mark as Exhibit 1, and that is the Notice of Deposition.

(Exhibit 1 was marked for identification and is attached to the transcript.)

BY MR. CRONE:

Q. Okay. Doctor, you've seen that document before?

A. I have.

Q. And what did you do to prepare for this deposition?

A. I reviewed medical records for Janet Webb, depositions, performed an IME.

Q. Which depositions did you review?

A. The deposition of Ms. Webb and the treating physician.

Q. Is that Dr. Edwards?

A. Dr. Edwards, yes.

Q. And anything else?

A. I have a medical chronology that I reviewed that was made from the medical records of Ms. Webb, and I have a portion of her medical records which may be pertinent.

Q. So you have her medical records that relate to her TVT implantation in 2003?

A. I do.

Q. And then a Prolene mesh implantation in 2013?

A. Correct, and a few medical records in between.

Q. Do you think there are any records missing that would be pertinent?

A. Well, if anything is missing, I don't know it. If there is something that relates to her during that time period, it could be pertinent, but I'm not aware of any.

Q. So you just reviewed what you've been given?

A. That's correct.

Q. And was it Butler Snow that gave you the medical records?

A. Mr. Combs.

Q. And what about the medical chronology?

A. I discussed the medical records with Mr. Combs, and the chronology was made from that for me to refer to.

Q. And do you recall giving deposition testimony in a case called Huskey v. Ethicon?

A. Yes.

Q. And do you believe you testified accurately in that deposition?

A. I do.

Q. And truthfully as well?

A. To the best of my ability.

Q. The Notice of Deposition asks you to bring

a variety of documents. What documents did you bring in response to that?

A. I brought my case-specific report, my medical chronology, key medical records that I had pulled from her medical records, and two depositions.

MR. COMBS: And in addition to that -- I'm sorry. I did not mean to interrupt you, Dr. Johnson.

THE WITNESS: And some handwritten notes that I made and the general report.

MR. CRONE: Okay.

MR. COMBS: And in addition to that, I have a thumb drive that is labeled Janet Webb that has an electronic copy of materials on Dr. Johnson's reliance list.

MR. CRONE: And that includes the materials on the reliance list and the supplemental reliance list?

MR. COMBS: It should. As I preface every single time we discuss it in depositions, I don't actually make the thumb drive. It should. If it doesn't have that, it is just a mistake.

MR. CRONE: Sure.

BY MR. CRONE:

Q. And, Doctor, just for the -- just to get this out of the way, can we take your notes and mark those as Exhibit 7?

(Exhibit 7 was marked for identification and is attached to the transcript.)

BY MR. CRONE:

Q. And then could you just tell me generally what the notes are regarding?

A. The notes are regarding the medical care of Ms. Webb, her medical history, surgical history, and doctor visits.

Q. So were the notes prepared in conjunction with your drafting of the expert report in this case?

A. The -- the expert report I prepared with Mr. Combs where drafts were prepared and edited. And then I made these notes this week because -- well, frankly, because I have six depositions of six different patients.

Q. Understood.

A. And writing -- when I write things, I remember them a little better. It helps organize them in my mind.

Q. So those notes are to help you with your recall for today's deposition?

A. That's right.

Q. Did you bring any documents reflecting your fees charged in this case?

A. I think that's reflected in the general report, which I have with me.

Q. The rates are reflected, correct?

A. That's correct.

Q. Okay. But not the actual fees incurred thus far with respect to Ms. Webb's case?

A. I haven't made a bill yet, but I'm happy to provide that to you when I do.

Q. Can you estimate how many fees have been incurred thus far in Ms. Webb's case?

A. I would estimate that I spent about 25 hours on this case.

Q. And that's not including today?

A. That's right.

Q. Have you ever acted as a consultant for Ethicon?

A. I've acted as a proctor for the TVT procedure in the early to mid 2000s.

Q. And can you estimate how much Ethicon paid you for those activities, acting as a proctor?

A. I don't know the specific number. I can only recall several times that I was a proctor. And

I think for a day, it was like $1,500 or $2,000, where a couple physicians would come and I would let them observe and show them how I performed a TVT on a patient.

Again, as I testified earlier, I don't know the exact amount. It's -- well, I just don't know the exact amount. I mean, it's low. I think it would certainly -- it's probably less than $10,000 and definitely, I think, less than $20,000.

Q. Has Ethicon paid you for any other type of work?

A. I prepared a general --

Q. Well, I'm sorry. Let me back up. Not -- excluding anything related to a case. So no expert reports, not trial testimony, not deposition testimony. Excluding all of that, have they paid you for any other type of work?

A. I don't think Ethicon directly, but I did some teaching for a company called IMET, which may have had some -- in that company, we taught all different types of procedures. And I don't really recall specifically when Ethicon was involved, but I think they may have been a sponsor. You would have to call the company and ask.

Q. Sure. So you're unclear on the

relationship between IMET and Ethicon?

A. Yes.

Q. Okay. I will hand you what we'll mark as Exhibit 2, which is your case-specific expert report in Ms. Webb's matter.

(Exhibit 2 was marked for identification and is attached to the transcript.)

BY MR. CRONE:

Q. Okay. Who asked you to write this report?

A. Mr. Combs.

Q. And these are your specific causation opinions relating to Janet Webb's case?

A. Yes.

Q. Okay. At the top of page 2, second sentence, you state: "I hold all opinions stated herein to a reasonable degree of medical certainty."

What does that mean?

A. That I feel that they're greater than 50 percent certain.

Q. Did you speak with any of Ms. Webb's treating physicians?

A. I did not.

Q. Any of the experts she has retained in this case?

A. I have not.

Q. Did you -- in reaching your conclusions expressed in Exhibit 2, did you conduct a differential diagnosis?

A. I did.

Q. You mentioned earlier that you reviewed an IME. Do you know who -- an independent medical examination of Ms. Webb. Who performed that?

A. I did.

Q. I'm going to hand you a series of exhibits here just to speed this up a bit. So Exhibit 3 is your CV.

(Exhibit 3 was marked for identification and is attached to the transcript.)

BY MR. CRONE:

Q. Exhibit 4 is your reliance list.

(Exhibit 4 was marked for identification and is attached to the transcript.)

BY MR. CRONE:

Q. Exhibit 5 is your supplemental reliance list.

(Exhibit 5 was marked for identification and is attached to the transcript.)

BY MR. CRONE:

Q. And Exhibit -- oh, let's stop there for now.

Okay. So let's look at your CV first, Exhibit 3. Is there anything that needs to be updated on this CV?

A. Under the specialty boards, recertification till 2015, and then subspecialty certification for female pelvic medicine and reconstructive surgery through the American Board of OB/GYN.

Q. And that's for 2015?

A. Yeah.

Q. And 2014?

A. 2014 there was -- I think it was -- there was one year in there where I missed the deadline for the exam and I had to apply for a re-entry exam, which I took two or three months after December 31st to re-enter into the certification process.

Q. And you're unsure if there was a lapse in certification during that re-entry process?

A. Right.

Q. Okay. And 2016, has that certification come up yet?

A. It's a yearlong process, so it's ongoing.

Q. So it will happen at the end of the year?

A. Right.

Q. Yeah. Okay.

And at page 7, invited speeches and presentations, is that a complete list?

A. No. This is a 2014 copy of my CV, so there may be additions to that. Probably not a lot.

The last thing is on the hospital medical staff appointments, the St. Joseph's Medical Center I've been reappointed because the University of Maryland acquired that hospital into the University of Maryland Medical System.

Q. Okay.

A. And so I reestablished credentials because they're part of our system now.

Q. And in a prior deposition today, you had offered to send an updated CV. And I assume that offer still stands?

A. Yes.

Q. Let's look at Exhibits 4 and 5, which are your reliance list and supplemental reliance list respectively. And are these all documents you reviewed in support of your opinions expressed in your expert report marked as Exhibit 2?

A. These were materials that were supplied to me by Butler Snow. And I've reviewed the materials that I think are pertinent but not every single title in this list.

Q. How many of these documents do you think you actually reviewed?

A. Well, this is essentially literature that's been published over my career, so at different points in time I've reviewed these when they weren't related to this case. So I've reviewed a great number of these articles just in general reading and board review, board certification, subspecialty certification over time.

Q. What about the Ethicon company documents that are listed? Did you review any of those?

A. I looked at them, but they didn't seem to provide me with any information that I felt I needed, so I didn't review the majority of them.

Q. Okay. So is it fair to say you didn't rely on everything that's listed in Exhibit 4 and 5 in forming your opinions with regard to Ms. Webb's case?

A. Yes.

Q. Do you know why they're included on your reliance list, then?

MR. COMBS: Object to form.

THE WITNESS: Well, I think they -- I'm -- I think Butler Snow tried to send me everything that they felt could be related to this, which is, as you

can see, a massive number of documents.

BY MR. CRONE:

Q. Okay. Let's turn back to your expert report, which is Exhibit 2. The second page -- and this isn't numbered, but the second page, yeah. At the -- right above Roman numeral I, Summary of Opinions Specific to Ms. Webb, you write a sentence that says: "A list of all other cases in which I testified in the previous four years is attached as Exhibit C."

And that Exhibit C is missing a couple of cases, correct?

A. Yes.

Q. Okay. And would one of those cases be Huskey v. Ethicon?

A. Yes.

Q. And another one was Rustan v. Cooper?

A. Yes.

Q. And the Rustan v. Cooper was a medical malpractice case?

A. That's correct.

Q. With the inclusion of those, you think that list is complete?

A. To the best of my ability. I don't really keep a list. And I looked through what records I

had to try to make the list as complete as I could.

Q. And under Roman numeral II, the first sentence there: "Ms. Webb was born on September 28th, 1952 and is" -- excuse me if I'm mispronouncing this -- "gravida 2, para 2," what does that mean?

A. That means she had two pregnancies and had two children.

Q. Let's move to the next page. Page 3 starts with -- at the top, it says: A, Pre-Implant Medical History. Let's see. It will be the third full paragraph under A. And it says: "In November 2003, Ms. Webb presented to the resident's clinic where Dr. Ben Edwards was employed and was diagnosed with cystocele grade 3, rectocele, stress incontinence, and possible uterine prolapse."

When you refer to stress incontinence there, you're not implying there was any other type of incontinence; is that correct?

A. That was, I believe, what was listed in that note. Let me just check.

That was her complaint that day as noted, was stress incontinence for a few years and urinary frequency every hour and constipation.

Q. And it's your understanding that her TVT

implant surgery was performed in December 2003? It's under B in your report, if that helps.

A. Yes.

Q. Oh, I'm sorry. Was that a yes?

A. Yes.

Q. I wasn't sure if you were saying yes to my reference or --

A. No.

Q. That was my fault.

And by June 2004, Ms. Webb was diagnosed with incontinence again; is that correct?

A. Yeah, June 8th, 2004. I'm sorry. I'm just trying to make sure I have the timeline right.

Q. I'll refer you where I can.

A. Okay.

Q. So is it fair, then, to say that the 2003 TVT implant procedure was not objectively successful?

MR. COMBS: Object to form.

THE WITNESS: Well, they didn't -- they didn't really describe the incontinence as stress incontinence or urge-type incontinence, but she was having some recurrent incontinence in June of '04.

BY MR. CRONE:

Q. And the TVT product is designed to treat

stress urinary incontinence?

A. That's right.

Q. So as of June 2004, you're unable to tell from the records whether or not that TVT implant surgery was successful because it doesn't state whether it's stress urinary incontinence or urge incontinence that she's being diagnosed with; is that fair?

MR. COMBS: Object to form.

THE WITNESS: In the note, they talked about her having urinary incontinence and they treated her as though it were urge incontinence with an anticholinergic medication.

BY MR. CRONE:

Q. And if it was urge incontinence that she was diagnosed with in June of 2004, that would be a new ailment that Ms. Webb had suffered since the 2003 TVT implant, correct?

MR. COMBS: Object to form.

THE WITNESS: What I am looking for is the referral note from Dr. Patil to Dr. Edwards, and I don't seem to have that. From what I have from the medical records, it's a new complaint.

BY MR. CRONE:

Q. Okay. Now, I'm going to ask you a series

of questions about Ms. Webb's medical history prior to the December 2003 TVT implant. And I know you can only answer these based on the medical records you have.

So prior to that date, December 2003 when the TVT was implanted, Ms. Webb did not have a history of recurrent UTIs; is that correct? And if it helps, Doctor, look at whatever you need to look at, but your pre-implant medical history has cites to it.

A. Okay. Yeah, I don't have any records to show that.

Q. And no records to show that she had a history of bladder infections?

A. Those are the same, urinary tract -- well, the bladder is more specific. That's true.

Q. No records to show she had a history of dyspareunia?

A. Yes. No.

Q. I know what you mean. Yes, there are no records?

A. Yes, there are no records.

Q. No history of complaints of pelvic pain?

A. True.

Q. No history of leakage?

A. Not in the records that I have.
Q. No history of fecal incontinence?
A. True.
Q. No history of painful urination?
A. True.
Q. No history of mixed incontinence?
A. True.
Q. No history of vaginal bleeding?
A. True.
Q. No history of voiding dysfunction?
A. Well, in 11/03, she had urgency -- or actually frequency. She describes feeling the need to urinate hourly.
Q. Is that the same as voiding dysfunction?
A. Well, that's not normal.
Q. No history of bed-wetting?
A. Correct.
Q. No history of general muscle weakness?
A. Well, in '01, there's a description of pain, swelling of hands, wrists, knees, ankles; rash on arms, face, neck. Patient presents with -- to see if she has a diagnosis of lupus. She has a history of photosensitivity; Raynaud's; painful, swollen joints; low back pain with radiation into the right leg without any definite numbness or

tingling, which is suggestive of lupus. She was started on a pain medication and steroids which goes along with those pain complaints.

Q. All of those symptoms she complained of, would you characterize any of that as general muscle weakness?

A. Well, that pretty much covered all the parts of her body and joints. I think it would be suggestive of that, yes.

Q. Now, I will ask the same series of questions but will focus on the time period after the TVT procedure, so after December 2003 to the present based on the medical records you have. So everything since December 2003 to the present.

Now does Ms. Webb have a history of UTIs?

MR. COMBS: Object to form.

BY MR. CRONE:

Q. So that's urinary tract infections.

A. It looks like she developed recurrent prolapse in 2007 and came in with quotations of fallen bladder -- that's her description -- and was diagnosed with a urinary tract infection and then had some urinary tract infections after that 2007 visit.

Q. How about bladder infections?

A. Well, a bladder infection is a urinary tract infection. The bladder is part of the urinary tract.

Q. So the answer would be yes?

A. Yes, it was a urinary tract infection that was called a bladder infection.

Q. Okay. How about dyspareunia?

A. I know when I conducted my IME last week she complained to me of dyspareunia. I'm just trying to look in the chart of when that was documented before I saw her.

Q. Do you recall if she said that started within a couple of months after the TVT implant?

MR. COMBS: Object to form.

THE WITNESS: She stated that she was not sexually active and she was unable to since 2003.

BY MR. CRONE:

Q. And why was she unable to have sex since 2003?

A. Well, she complained of introital dyspareunia. In addition, I would say she had a very shortened vagina from her surgery. She had fairly extensive surgery at the time of the TVT.

Q. And still in this line of questions about what she has a history of since the 2003 implant,

how about pelvic pain?

A. She has complaints of a lot of different pains in her body, but I don't really have a note discussing pelvic pain other than the findings on her examinations of shortened, scarred vagina, atrophic vaginitis, these types of things, which certainly pain goes along with previous surgery.

Q. How about leakage?

A. She does have complaints of leakage.

Q. Okay. And fecal incontinence?

A. Yes.

Q. Painful urination?

A. Yes.

Q. Urge incontinence?

A. Yes.

Q. Mixed incontinence?

A. Yes.

Q. Bed-wetting?

A. Well, I don't see in the medical records that I have a complaint of bed-wetting, but --

Q. How about vaginal bleeding?

MR. COMBS: Did you say vaginal pain?

MR. CRONE: Vaginal bleeding.

MR. COMBS: Okay.

MR. CRONE: Sorry.

BY MR. CRONE:

Q. And if it helps, Doctor -- of course review whatever you need to -- in your expert report, under C, Post-Implant Medical Condition, it lists various things I believe with citations to the medical records. So specifically I'm looking at page 4 in the third paragraph at the bottom about in the middle of that paragraph.

A. Well, that was taken from the medical record. I just can't find that note. I mean, I don't have all the medical records here.

Q. Okay.

A. But I did state that.

Q. Okay.

A. Which is not -- well, I stated that in 2013 she came to Dr. Caputo, and those were one of the descriptions from Dr. Caputo in 2013. She had significant vaginal atrophy at that time, so it's not surprising.

Q. And then in that same note, it notes voiding dysfunction?

A. Yes.

Q. And Ms. Webb also complained of general muscle weakness. And that's on page 5, first paragraph at the top. Is that correct?

A. Yes.

Q. Dr. Johnson, what is vaginal atrophy?

A. Vaginal atrophy occurs after menopause when you don't have estrogen in your body. And it's a thinning of the vaginal mucosa that occurs in postmenopausal -- most commonly in postmenopausal women. It's a lack of estrogen.

Q. Does it respond typically to estrogen cream?

A. It can. It doesn't always, but it can.

Q. Does it cause dryness?

A. Yes.

Q. So on page 5 of your report, which has Roman numeral III on it, under A, which is titled Ms. Webb Was An Appropriate Candidate For TVT, the second paragraph there, second sentence says: "Compared with other available treatment options, TVT was among the safest and most effective choices for long-term resolution of Ms. Tomblin's SUI."

Who is Ms. Tomblin?

A. That was one of the other -- that's one of the other cases that I reviewed this week and prepared reports. That's an error.

Q. So that's a typo?

A. Yeah, that's a typo.

Q. Are there any other portions of Ms. Webb's case-specific report you prepared that might have Ms. Tomblin's information in it rather than Ms. Webb's?

A. I don't believe so. I'd have to look back at it, but I don't believe so.

Q. Okay. The next page, page 6, it starts -- at the top, there's a heading that says: "Ms. Webb's pelvic pain and dyspareunia were not caused by defects in her TVT." So is it your opinion that her preexisting medical conditions caused her pelvic pain and dyspareunia?

MR. COMBS: Object to form.

THE WITNESS: Well, I think she had --

BY MR. CRONE:

Q. And I'm sorry. Let me clarify it now that I think about it.

By preexisting, I mean pre-December 2003 TVT implant. So those conditions, is it your opinion that those are causing her pelvic pain and dyspareunia?

MR. COMBS: Objection to form.

THE WITNESS: I think that Ms. Webb has a large number of medical conditions that developed or were present during this time, both before the

implant and then developed afterwards. They're all chronic medical conditions that can result in pain, in generalized pain, pelvic pain.

BY MR. CRONE:

Q. What about dyspareunia?

A. And dyspareunia, yes. And that includes her surgical procedures.

Q. And then what is your basis for those opinions? We'll start with the pelvic pain.

A. Well, she developed significant vaginal atrophy. She had a severely scarred vagina from the surgeries that she had at the time of the -- that were concurrent with the TVT, which in themselves could cause dyspareunia and pelvic pain.

She has constipation, which is -- can be fairly significant in somebody that uses a lot of narcotic medications for pain, which can lead to pelvic pain and dyspareunia.

Q. Does Ms. Webb use narcotic pain medications?

A. She does.

Q. And it's your opinion she uses a lot. What do you mean by that?

A. Well, I mean, just looking through her medical record, there's a fairly significant number

of narcotic prescriptions, so almost at times refills monthly in increasing doses.

Q. Is it normal to develop some sort of, I'll call it, resistance to narcotic pain medications resulting in the need for increasing dosages?

A. Well, certainly there's tolerance where you may require more medication. That's with regular use generally.

Q. And so somehow that's related -- or causing, excuse me, her pelvic pain or dyspareunia?

A. Well, one of the things I was talking about was constipation, which with a full rectum can cause pelvic pain and dyspareunia.

Q. But you don't know that the constipation is caused by her medication use?

MR. COMBS: Object to form.

THE WITNESS: Well, I know constipation is associated with narcotic use.

BY MR. CRONE:

Q. Sure, but I mean specific to Ms. Webb, you don't know if those two things are linked?

A. Well, I know she's at times a regular user of narcotic pain medication.

Q. Sure, but you don't know if she's suffering that side effect?

A. Well, I know there's a complaint of constipation.

Q. But my question is: You don't know that the constipation is linked to her medication use?

MR. COMBS: Object to form.

THE WITNESS: Well, I think -- I think all of these things that she has go together. She has a long list of medical conditions that can be interrelated, and I think that those two are interrelated.

BY MR. CRONE:

Q. When the TVT is placed, it's my understanding that trocar arms go through the levator muscles. Can you explain that just very briefly?

MR. COMBS: Object to form.

THE WITNESS: Well, the trocar needles go periurethral into the space of Retzius, which is behind the pubic bone, if you will. They don't go posterior into the area around the rectum and lateral to the rectum. So they're in the anterior wall of the vagina, not the posterior wall.

BY MR. CRONE:

Q. Do they go through something called the levator muscle group?

A. Well, the levator ani --

Q. Or levator ani. I'm sorry.

A. The levator ani is a large muscle that covers the whole pelvic floor.

Q. Okay. And those trocar needles go through that portion of the anatomy?

A. Well, they go -- they go through the anterior wall of the vagina through the space of Retzius periurethrally, the anterior wall of the vagina, not posteriorly into the pelvic floor posteriorly.

Q. Do they pierce any needles or -- muscles? I'm sorry.

A. They do go anteriorly through the space of Retzius and through the rectus muscles, insertion at the pubic bone.

Q. So it's possible that could cause pelvic pain, isn't it?

MR. COMBS: Object to form.

THE WITNESS: Well, that -- pelvic pain encompasses so large of an area. But the area where this is is suprapubically at the pelvic bone, in other words, at the front of your lower abdomen, which is part of the pelvis. So you would say -- I mean, if you're just using a general term, that's

pelvic pain, but it doesn't give you a location.
BY MR. CRONE:
Q. Sure, but I mean, it's possible it could cause pain in the pelvic area, that procedure?
A. Well, it is a surgical procedure, so there's an incision and insertion of needles, and that can result in pain.
Q. And the TVT is placed near the entrance of the vagina; is that correct?
A. Yeah, at the midurethra.
Q. At the midurethra.
A. Yeah.
Q. So it's possible, then, that the TVT's placement could cause dyspareunia?
A. Well, I would agree with that because any -- any surgical procedure in the vagina where you make an incision and perform an operation can result in pain.
Q. Okay. Let's go to the bottom of page 6. I think you're still on page 6. And directing you to that area and that --
A. I'm sorry. Is that C or --
Q. It's at the bottom of page 6. It's under B.
A. Under B. Okay.

Q. And in that paragraph, you're discussing the numerous pain conditions that cannot be ruled out. Those are your words. And you talk about a history of fibromyalgia, low back pain, degenerative changes in the lumbar spine, hypothyroidism, and lupus as well as rheumatoid arthritis and osteoporosis.

So can you explain starting with -- well, let's just start with fibromyalgia, how that might cause pelvic pain or dyspareunia.

A. Well, fibromyalgia, you can have general pains throughout the body. So I listed these together because I think they all interact to cause pains throughout the body. There's going to be joint pain, muscle pain. Lupus can cause significant disability in that way, as can rheumatoid arthritis and osteoporosis. So all of these things combined can result in pain like this.

Q. So then it's your opinion that fibromyalgia could cause pelvic pain?

A. Well, what I'm saying is all of these things taken together in addition with her surgical procedure and her vaginal atrophy can result in pain.

Q. So pain but not necessarily pelvic pain?

A. No. It can be pelvic pain. It's pain throughout the body.

Q. Also dyspareunia?

A. Well, you can have pain -- it depends on, if you're talking specifically about vaginal pain, whether you're having pain with intercourse from your body being really -- having a lot of medical conditions that affect all your joints, muscles, and et cetera. So that combined with the vaginal atrophy and the scarring from her surgery can all result in pelvic pain and dyspareunia, which is a type of pelvic pain.

Q. Okay. Well, it's my understanding -- and correct me if I'm wrong -- that dyspareunia is pain during sexual intercourse, vaginal intercourse; is that correct?

A. It's pain during intercourse or sexual activity.

Q. Okay. And so it's your opinion, then -- and if I mischaracterize this, please correct me -- all of these conditions listed -- fibromyalgia, low back pain, degenerative changes in the lumbar spine, hypothyroidism, lupus, rheumatoid arthritis, and osteoporosis -- can combine to cause dyspareunia?

A. Well, they combine to cause pelvic pain

and may be uncomfortable during intercourse with the act of performing intercourse. But I wouldn't say all these things cause pain in the vaginal mucosa. That would more be related to her vaginal atrophy and her previous surgical procedures performed in 2003.

Q. And Ms. Webb's dyspareunia, she complains of the pain being at the entrance to the vagina; is that correct?

A. Well, again, I'm combining the medical record with my examination of Ms. Webb. But I found in my independent examination pain throughout the vagina. And I found a short -- a very short vagina, less than 40 percent of its normal length, and palpable sacrocolpopexy mesh at the apex which was very tender.

Q. But Ms. Webb has only complained of dyspareunia at the entrance of the vagina, correct? I mean, I understand you did a --

A. Oh, yeah. I mean, when I was talking with her, you couldn't even -- she really didn't even want you to examine her because the whole vagina was atrophic, painful, shortened, scarred severely.

Q. Okay. Let's turn the page. And the first full paragraph says: "Similarly, Ms. Webb suffered

from preexisting medical conditions that likely inhibited her body's capacity to heal. Specifically, Ms. Webb suffered from chronic leukopenia." That is low white blood cell count and lupus.

So the question is: How did lupus impede healing and Ms. Webb's ability -- well, let's just start with healing.

A. Well, I think lupus is a chronic disease of the body that affects all systems in the body, and they can have trouble with medical issues such as healing, things like that.

Q. And Ms. Webb had lupus prior to her 2003 implant?

A. In December of 2001, she had a lot of these symptoms of pain, swelling in the hands, wrists, knees, ankles; rash, face, neck; the chronic -- chronic total body complaints, and was seen at Ashland Bellefonte Center to see if she had lupus. She had photosensitivity, Raynaud's disease, swollen joints. So she was diagnosed with symptoms suggestive of lupus, started on Mobic, which is a type of anti-inflammatory, and prednisone for this. She was seen again in May of '02 with a diagnosis of lupus and fibromyalgia.

Q. So she had lupus when Dr. Caputo performed the 2013 surgery?

A. Yeah. They first started talking about lupus in 2001.

Q. And she healed fine from Dr. Caputo's 2013 surgery, correct?

MR. COMBS: Object to form.

THE WITNESS: Well, she has a lot of problems in the vagina from scarring and pain and palpable mesh, atrophy. So, I mean, I don't think it's normal.

BY MR. CRONE:

Q. Well, is there anything in the notes to indicate that there was anything abnormal postoperative to Dr. Caputo's surgery in regards to healing and that sort of -- recovery and that sort of thing?

A. Well, I mean, if you -- if what you're asking me is did her incisions in the operation heal, it healed, but she didn't heal so that she was normal and improved.

Q. Okay.

A. I mean, there was some suspension of the vagina, and that was still true at the time of my IME, although the vagina was heavily scarred and

shortened, a significant portion was missing.

Q. In the next paragraph, you attribute her pelvic pain and dyspareunia to being likely caused or exacerbated by her mental condition. And by that you're referring to depression. Did I characterize that correctly?

A. Yeah. Depression has -- can have some effect on pelvic pain.

Q. And dyspareunia?

A. Yes, combined with atrophy and the other medical conditions that she has.

Q. And what's your basis for that opinion?

A. Well, there's known -- sexual dysfunction is known to occur in people with depression and psychiatric diagnoses.

Q. Is there a subspecialty of medicine that studies depression?

A. Well, there's psychiatrists.

Q. Are you a psychiatrist?

A. No, I'm not.

Q. Psychologist?

A. No.

Q. So you can't really hold this opinion with any sort of certainty, can you?

MR. COMBS: Object to form.

THE WITNESS: Well, sexual dysfunction is often seen by gynecologists rather than psychiatrists or with psychiatrists because psychiatrists typically don't perform pelvic exams. So it is within the scope of gynecology to talk about sexual dysfunction.

BY MR. CRONE:

Q. But if you had a patient who came to you complaining of dyspareunia and you thought it was caused by a psychological condition, you would refer that patient to a specialist, wouldn't you?

A. If I felt like evaluation and treatment would help her, I would.

Q. Okay. In the next paragraph, you mention that she was menopausal prior to the 2003 surgery and that this is known to cause vaginal dryness, loss of elasticity in vaginal tissues, both of which can result in dyspareunia. What's the basis for that opinion?

A. Vaginal atrophy is caused by decreased estrogen, thinning of the vaginal mucosa, dryness, which can result in pain, dyspareunia. You know, dyspareunia in women after menopause is not uncommon due to that.

Q. What's the typical treatment for that?

A. Estrogen cream would be probably one way. The other things that we have are other methods of delivery of estrogen to the vagina.

Q. And Ms. Webb tried estrogen cream, didn't she?

A. She -- she did have estrogen cream.

Q. Okay. So then is it your opinion that the estrogen cream did not work insofar as treating her dyspareunia?

A. Well, the estrogen cream would have -- the idea is that that would have helped with the vaginal atrophy. Again, I would reference my IME exam which showed, in addition to severe atrophy, a severely scarred vagina with approximately 60 percent removed -- and I give you that number based on my measurements of the vagina -- with palpable colpopexy mesh at the apex that was significantly tender.

Q. So the -- one of the surgeries could be causing the dyspareunia, not menopause. That's at least possible, correct?

A. Well, I think those go together. I don't think you can really separate them in this case. I think the surgery that she had to her pelvic floor was -- with the hysterectomy and the anterior and

posterior colporrhaphy was quite extensive and resulted in removal of a significant amount of the vagina.

Q. In the next paragraph, you say: "Finally, to the extent Ms. Webb's pelvic pain and dyspareunia are related to her TVT, it is unlikely her pain was caused by a defective or dangerous condition in the TVT."

What's your basis for that opinion?

A. I haven't seen any defects in the TVT mesh.

Q. Okay. So you, meaning yourself, personally have never seen a defect in a TVT mesh?

A. Well, I'm not aware of any defects in the literature. And I generally inspect the mesh before I place it. And I would expect that to be done when it's placed.

Q. Okay. When you inspect the mesh before placement, would you know what you were looking for if you were looking for a defect?

MR. COMBS: Object to form.

THE WITNESS: Well, I know what a normal TVT mesh looks like, so I would look for something that's not present in a normal piece of TVT mesh.

BY MR. CRONE:

Q. So if the TVT mesh in its normal condition was, in fact, defective, you wouldn't know that; is that fair?

MR. COMBS: Object to form.

THE WITNESS: Well, what I would be looking for -- if the mesh is handed to me by a tech in the operating room and if the mesh were compromised when it was removed from the kit, I would be looking for that or a break or a stretch, you know, something that happened as the mesh was handed to me.

BY MR. CRONE:

Q. Something visible to the naked eye?

A. Yes.

Q. Okay. In the same paragraph, last sentence, you write: "Although Ms. Webb may not have had a perfect result from her TVT, the use of TVT gave her the best chance for treating her SUI with minimal complications."

A. I'm sorry. I think I've --

Q. Did I lose you?

A. Yeah.

Q. So on page 7 above paragraph C --

A. What's at the top?

Q. At the very top, there's nothing, but sort

of near the bottom, it's labeled C.

A. Oh, here.

MR. COMBS: He's asking about that sentence (indicating).

BY MR. CRONE:

Q. Okay. So are you with me?

A. Yeah.

Q. Okay. So you write she didn't have a perfect result. In fact, the TVT did not objectively cure her SUI; is that correct?

A. Not long term.

Q. And she did, in fact, suffer numerous complications; is that correct?

MR. COMBS: Object to form.

THE WITNESS: Well, complications from the surgery in that she has a shortened, severely scarred vagina and she has suffered recurrent prolapse of that shortened vagina, which was treated with a second surgical procedure. But I don't agree that the TVT caused the complication and the second prolapse, if that's what you mean.

BY MR. CRONE:

Q. No. No. I am talking about the recurrent UTIs, for example.

A. Oh. Well, that one -- that one is a

little difficult. It looks like the UTIs started occurring after 2007 when she had her presentation for recurrent prolapse.

One of the -- kind of the confusing things here is when I talked with her about that, at the time she was working as a cashier at Walmart. And the working situation at Walmart at that time was such that she was not allowed to go to the bathroom during working hours, if you can believe that.

Q. I do.

A. And the way that she got around that was she wore a heavy diaper and urinated and had bowel movements in the diaper which she changed at the end of the day, which is -- I mean, having bowel movements in your pants and having that in your pants all day long of course would make you more susceptible to urinary tract infections because the bacteria is E. coli., which is the most common bacteria to give you a urinary tract infection.

So the -- I found that really remarkable, I guess is --

Q. I would agree with your description.

A. I don't even want to talk about it.

Q. Can the TVT cause blockage of the urethra? Is that a complication?

A. The TVT, if it's placed too tight, can obstruct the urethra, but generally if you don't have that obstruction when you first place it, it doesn't obstruct over time.

Q. If you do have an obstruction of the urethra caused by the TVT, that could cause a person to be unable to completely void; is that right?

A. Obstruction means that you've obstructed the flow of urine out of the bladder so you have difficulty voiding. You may require a catheter. I mean, in that case, you would have to use a catheter to drain your bladder.

Q. And in that case, that could lead to bladder infections?

A. Well, you can -- elevated post-void residuals or urinary retention you can have bladder infections. I'm not sure that I have evidence in this chart that she had --

Q. Well, she had bladder infections.

A. No, urinary retention. I know she had bladder infections. That's what I was talking about for a minute --

Q. Okay. Gotcha.

A. -- the way that she was managed at Walmart.

Q. If there's evidence of urinary retention in the records you have, then would you agree it's possible the TVT could have caused her bladder infections?

MR. COMBS: Object to form.

THE WITNESS: Well, at the time that she presented in 2007 when she had recurrent prolapse, it was recurrent prolapse of the anterior vaginal wall, which is the bladder. And as the bladder -- as the bladder drops with the prolapse, it can cause urinary retention. I would be more in agreement that she had urinary retention that was associated with her recurrent prolapse.

BY MR. CRONE:

Q. Okay. But can you conclusively rule out the TVT?

A. I don't have any -- I would have to see when that occurred and look at her evaluation at that time to give you an answer to the question.

Q. Okay. Under paragraph C, same page, first full paragraph, second sentence, it says: "It is my opinion that these urinary symptoms were not caused by defects in Ms. Tomblin's TVT implant or the TVT procedure."

Is that another typo?

A. I don't think I can directly say that her urinary symptoms were caused by the TVT implant or the procedure.

MR. COMBS: Dr. Johnson, he --

MR. CRONE: Go ahead.

MR. COMBS: He was just -- he's just asking you about -- it's got Tomblin's name in it -- whether it's a typo. He was asking you, is that a typo.

THE WITNESS: Yeah, that was -- that's a typo.

BY MR. CRONE:

Q. Okay. And so you're sure that -- again, you're sure that there are no opinions reflected in this report that actually relate to Ms. Tomblin rather than Ms. Webb?

A. Yes.

Q. Okay.

A. To the best of my ability, yes.

Q. Okay. Let's go to the top of the next page. The first paragraph that's not a full paragraph, last sentence says: "If Ms. Webb suffers from post-implant urinary incontinence, her prior incontinence would be the cause."

So are you opining here that SUI can lead

to urge incontinence?

A. What I'm talking about really is when you have stress incontinence and you have a procedure to treat the stress incontinence, it's not a hundred percent that the stress incontinence will be cured. And it's not a hundred percent it will be cured over time.

Now, in addition to that, you can develop urge incontinence after the procedure over the course of your life, which may or may not be related to the procedure. In this case, again, she had significant surgery to the vagina, and I would -- you know, there's a chance of recurrence of stress. There's a chance of development of urge incontinence.

Q. But just to be clear --

A. And there's a chance of urge incontinence whether you had the surgery or not.

Q. Sure. But just to be clear, stress incontinence does not directly cause urge incontinence?

A. No.

Q. Throughout the report, you use the words likely or unlikely in reference to various opinions. So, for example, if you go to the paragraph just

above D on the same page, in the first sentence of that last paragraph, it says: "Finally, to the extent Ms. Webb's urinary problems are related to her TVT, it's unlikely her urinary problems," et cetera. The sentence goes on.

By likely or unlikely, what sort of certainty are you describing?

MR. COMBS: Object to the form.

BY MR. CRONE:

Q. And if you don't understand the question, I'll ask it again.

A. Okay. You can ask me again.

Q. Sure. So here where you say: "It is unlikely her urinary problems were caused by a defective or dangerous condition in the TVT," that's a conclusion. Would you agree?

A. Yes.

Q. That's your opinion?

And you're qualifying that opinion by saying it's unlikely. So how sure are you that her urinary problems were not caused by a defective or dangerous condition in the TVT?

MR. COMBS: Object to form.

THE WITNESS: The conditions that she has with her bladder and vagina are conditions that are

known with all surgeries for stress urinary incontinence, and the occurrence is very similar in all of these procedures. In other words, they occur around a similar amount.

So my opinion is that these things occur with this type of surgery whether you use a mesh or whether you use a pubovaginal fascial sling or whether you use a Burch colposuspension, especially when these things are combined with extensive pelvic floor surgery like she had and has had.

BY MR. CRONE:

Q. So when you say it's unlikely, then, that her urinary problems were caused by a defective condition in the TVT, implicitly you're stating that there may be other causes?

A. Yes.

Q. Okay. Let's go to the very bottom of that page, the last sentence. It says: "At the time of Ms. Webb's TVT implant in 2003, dyspareunia, pain, urinary dysfunction, and urinary tract infections were all well-known complications in the medical community, especially among gynecologists like Dr. Edwards, based on reports and studies in the peer-reviewed literature."

So is your basis for that opinion just the

reports and studies, or is there more?

A. The medical literature. So that would mean like information from ACOG societies, AUGS meetings, things like that.

Q. Do you know if Dr. Edwards read any of that literature?

A. He testified that he was aware of these complications, so I don't know what -- I can't recall in his deposition if he said that, but I do recall that he testified that he was aware of the complications.

Q. He didn't testify that he was aware that mesh could curl, rope, contract, or shrink, did he?

MR. COMBS: Object to the form and foundation.

BY MR. CRONE:

Q. It's a very compound question.

So you reviewed Dr. Edwards' deposition, correct?

A. I did.

Q. And in reviewing that deposition, do you know whether Dr. Edwards testified that he was aware that the TVT mesh could curl?

A. I would have to reread the deposition to look for those complications.

Q. Same question with his awareness that it could rope.

A. Same answer.

Q. Same question with regard to contraction.

A. Same answer.

Q. And shrinkage.

A. And I would say with those -- with all of those issues, I would have to look in his deposition to see if he testified to that. And I haven't seen that really in the literature.

Q. That's fair.

If you reviewed his deposition testimony and he did not testify that he was aware of those things, would that change your opinion here about what Dr. -- about the complications Dr. Edwards was aware of?

MR. COMBS: Objection to form.

THE WITNESS: No.

BY MR. CRONE:

Q. Okay. All right. Let's look at your IME of Ms. Webb, which I think I held back on because I flooded you with exhibits.

MR. CRONE: So we'll mark this as -- I believe this should be 6.

(Exhibit 6 was marked for identification

and is attached to the transcript.)

BY MR. CRONE:

Q. So, Dr. Johnson, Exhibit 6 is -- this is your IME report from your examination of Ms. Webb?

A. Yes.

Q. Okay. I have a few -- just a few questions on this. They're largely due to my unfamiliarity with reading these types of documents.

So the third line down under HPI, that mild incontinence you're noting, does that refer to her stress incontinence?

A. Yes.

Q. Okay. And then the eighth line from the bottom of that section, you noted: "She complained of mixed incontinence, recurrent UTI, and vaginal bleeding."

And these are all complaints after the 2003 TVT implant, right?

MR. COMBS: Could you read that question back?

(Pending question read.)

THE WITNESS: Yes.

BY MR. CRONE:

Q. And then the second line from the bottom there says: "She cannot void when slumped."

What could be causing that?

A. Well, those were her words. Generally you sit up to void, but she had a severely scarred vagina. So that's what she said, she couldn't lean forward and void, but that's not a normal voiding position anyway. I just wrote down what she said.

Q. Okay. Let's go to page 2. Under sexual function near the bottom, the introital dyspareunia that she complained of, that means dyspareunia near the entrance of the vagina, right?

A. Yeah. She complained of -- well, she wouldn't allow anything to go into the vagina because of tenderness all the way around and all the way -- it was very difficult to do an exam because of that.

Q. And she's been that way since 2003. Is that what that note above means with regard to sexual activity?

A. Since her pelvic floor surgery in 2003.

Q. So the next page, under past surgical history, which is kind of near the top, the last entry there says Prolene mesh. Is that the 2013 surgery you're referring to?

A. Yeah, that's a description from the colpopexy abdominal approach.

Q. Okay.

A. Yeah, I'm sorry the date's not on there. It should be 2013.

Q. Then under past medical history, you note urge incontinence. And I know we've gone over this, but I just want to make sure. That's urge incontinence that developed after her 2003 TVT implant; is that right?

MR. COMBS: Object to form.

THE WITNESS: I didn't have records showing urge incontinence before 2003.

BY MR. CRONE:

Q. Okay. Let's go to the next page. It's the table at the bottom, GYN.

A. Yeah.

Q. You note external genitalia is gaping. What does that mean?

A. That means when you -- the patient is in lithotomy position and you are just looking at the genitalia, the vaginal opening is gaping open. In most women, it would be closed or the side walls would be touching, not open.

Q. Under vaginal pelvic support in the same table there --

A. Yeah.

Q. -- you note: "Atrophic vaginal mucosa, scarred, tender to touch, palpable mesh at apex, difficult to place speculum, shortened vagina."

So let's start with the difficulty in placing the speculum. Could that be due to the TVT's placement near the entrance of the vagina?

A. My impression during the exam was that the entire pelvic floor was painful. She wouldn't -- I found it very difficult for me to do anything, especially since the vagina is shortened. Almost as soon as you put the speculum in, it hits the apex of the vagina, if you will. Because a normal vagina would be more like 10 centimeters and then after hysterectomy, 7 to 8 centimeters, maybe 9. And then hers was 4 centimeters in length, which means almost as soon as you put the speculum in, you hit the top apex, which was very painful for her.

Q. Okay. So it was primarily difficult to place it because it was painful due to the shortened vagina?

A. And scarring.

Q. And scarring.

And atrophic vaginal mucosa that's scarred and tender to touch, what do you mean there exactly?

A. Well, all I really mean is that the

vaginal mucosa was very atrophic, which means thinned out, lack of menopause, dry, inflamed looking, scarred from her previous surgery, which is evidenced by the shortened vaginal length. And then when I touched the apex and the vagina around -- actually almost everywhere, it seemed like it was very tender. And I could palpate the mesh that had been attached to the apex.

When you attach the mesh to the apex, it's not just -- it's not just attached just to the apex. It goes usually 2 or 3 centimeters at least on either side, which means the anterior wall and the posterior wall. So it has to be sewn in along the anterior wall and sewn in along the posterior wall, and you could actually feel that.

Q. When you say "feel that," do you mean feel the mesh directly or underneath?

A. I mean underneath the mucosa. So there was no exposure or erosion of the mesh.

Q. Was there anything else abnormal about the mesh?

A. Well, I couldn't see the mesh. The -- she just had a lot of scarring and a very tender anterior and posterior wall where it was attached. I mean, I think it was easy to palpate because of

the fact that it was attached to both the anterior and the posterior walls for a couple centimeters. She just did not like you to touch that.

Q. Okay. Could it have been easy to palpate because it had contracted?

MR. COMBS: Object to form.

THE WITNESS: I don't think that would have made any difference.

BY MR. CRONE:

Q. Does the scarring make any difference in how easy it is to palpate the mesh?

A. Well, you know, I think that what's really significant here was that her vagina was so atrophic and so thinned out that anything that you put behind there you would feel.

Q. And when you were examining Ms. Webb, did she complain of pain essentially anywhere you touched her in the vagina or was it only when you touched certain areas, for example, the mesh?

A. The mesh apex was so painful that she was fearful of any touch, so it was somewhat difficult for me to examine her. I had to -- the way I examined her was that if I -- if I did something in the exam that hurt and she told me to stop, I would stop.

Q. Okay.

A. So that was the problem with the -- when I touched the apex, she told me stop, and we did.

Q. And when you're examining her, she doesn't know where you're touching exactly? By that, I mean she can't see exactly where you're touching while you're doing it; is that fair?

A. Well, I usually inform a patient of what I'm doing so that I don't surprise them or -- it's just a technique to talk what you're doing while you're doing an exam so that the patient is more in control than the doctor to try to not cause any pain or discomfort or fear.

Q. And did you do that in this case?

A. Yes.

Q. Okay. Next page. Under levator muscle strength 2 out of 5, what does that mean?

A. Well, when I had a finger in the vagina, I asked her to contract or try to squeeze the muscles and her squeeze was somewhat weak.

Q. Okay. And --

A. In other words, the lower the number, the weaker the contraction.

Q. What is a reduction stress test?

A. A reduction stress test is if you have

prolapse and you have to push the vagina in for them to void.

Q. Okay.

A. So I've tried to hold -- I don't mean void. I mean to -- a stress test means to cough, laugh, or sneeze. So you support the anterior vaginal wall and have them cough, laugh, or sneeze and see if they leak.

Q. And here you did that. Negative means she did not?

A. Right, she didn't with just a stress like a cough. When I was looking, there was no leak. And then when I put my fingers in for the exam, I had her cough and no leak.

Q. Okay. And then under --

A. And it refers to stress incontinence. That's what stress means.

Q. Okay.

A. Yeah. Yeah.

Q. And then under assessment, you note that, sort of right in the middle: "Shortened, scarred -- oh, I'm sorry. The line below that -- "Vagina is shortened from overzealous A&P -- that stands for anterior and posterior, right?

A. Yes.

Q. -- "colporrhaphy."

What do you mean by overzealous?

A. I mean that a significant amount of the vagina was removed, causing her vagina to be shortened and severely scarred. And that's the -- when she had recurrent prolapse, that's why the only option open to her from Dr. Caputo's recommendation was sacrocolpopexy, because the vagina was so short, she couldn't support it any other way.

Q. Okay. And you testified earlier that you performed a differential diagnosis in reaching your conclusions regarding Ms. Webb; is that correct?

A. Yes.

Q. Where is that reflected in this report?

A. Well, I think it's just the basis -- I mean, it's just the information in the report where I talked about the different diagnoses that she has and the possibility of her having pain from the different medical conditions that she has.

Q. So would you say, then, that it starts at page 5, Roman numeral III, Discussion of Opinions Specific to Ms. Webb, and then continues to page 8 and stops before Dr. Edwards was aware of the relevant risks?

MR. COMBS: Objection to form.

THE WITNESS: Well, it starts from her -- when I started talking about her post-implant medical conditions to the discussion of the different findings that we had.

BY MR. CRONE:

Q. So that's at page 3 --

A. 3 to 8.

Q. 3 to 8.

Has Ms. Webb ever been diagnosed with anxiety?

A. I'm just looking at my notes, and the diagnosis that I have from her records is depression. I don't have anxiety.

Q. Okay. So on page 10, the second paragraph -- excuse me -- the second full paragraph at the top of the page, it starts: "In addition," it says, "Dr. Veronikis' failed to provide a reasonable medical basis for excluding some of Ms. Webb's preexisting conditions and comorbidities including lupus, arthritis, anxiety, depression, and osteoporosis as causes or contributors to Ms. Webb's pelvic pain and dyspareunia."

Is the anxiety there a typo?

A. Yes.

Q. No possibility that this could relate to

Ms. Tomblin's case?

A. I don't think so.

Q. And you disagree with Dr. Veronikis' conclusions in his expert report; is that fair? And by that, I mean his conclusion that the TVT caused Ms. Webb's pelvic pain, dyspareunia, urinary problems, and UTIs.

A. Yes. I think it's much more -- her history has many more significant things in it to make it that simple.

Q. And the same question for Dr. Ostergard's opinion.

A. Yes.

Q. Just a couple more. We're just about done.

You had noted that the -- there's a similar risk of erosion from the Burch suture as the TVT procedure. What's your basis for that opinion?

A. In the Schimpf meta-analysis, the return to operating room for erosion with a Burch was .28 percent; and with the TVT, it was 1.9 percent; for the pubovaginal sling, 1.6 percent.

Q. That's quite a bit higher than the Burch procedure, wouldn't you agree?

A. Well, I consider them both very low. Even

though it's a low occurrence for both, there's a difference between the two.

Q. About five times the difference for the Burch procedure; isn't that right?

A. Yeah, I mean, they're both less than 2 percent, but they're both low.

Q. Just a couple last questions.

When Dr. Edwards performed the TVT surgery in 2003, did he do so within the standard of care? And I know there were many other procedures done. I'm just referring to the TVT procedure.

A. Okay. I think all the procedures that he did were within the standard of care as described in this medical record.

Q. And then the procedure performed by Dr. Caputo in 2013, was that performed within the standard of care?

A. Yes.

Q. And finally, does this report encompass all of the opinions you intend to offer in this matter?

A. Yes, unless there were records or information that haven't been made available to me which I don't know of.

Q. So if there are additional documents you

review and your opinions change, then you'll supplement this report?

A. That's correct.

MR. CRONE: I'm done.

MR. COMBS: All right. Let's take a break for a minute. I'm going to have very brief redirect. It's going to be less than five minutes.

(A recess was taken.)

EXAMINATION BY COUNSEL FOR DEFENDANTS

BY MR. COMBS:

Q. Dr. Johnson, I just want to ask you a couple of questions.

During Mr. Crone's exam, he was asking you about mesh that was palpable during the IME of the Plaintiff. Now, was that mesh that had been placed during the TVT or mesh that had been placed during the prolapse repair in 2013?

A. It was the colpopexy mesh.

Q. And Mr. Crone asked you questions about whether all of the opinions you had were set forth in your case-specific report. Did you also issue a general report that's applicable to this case?

A. I did.

Q. And will you also be offering opinions that are set forth in your general report upon which

you were deposed earlier today?

A. Yes.

MR. COMBS: All right. Thank you, Dr. Johnson. I don't have any more questions. I appreciate it.

MR. CRONE: I don't either.

MR. COMBS: Thank you.

(Off the record at 1:14 p.m.)

CERTIFICATE OF NOTARY PUBLIC

I, Samara J. Zink, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me to testify to the truth, the whole truth, and nothing but the truth concerning the matters in this case.

I further certify that the foregoing transcript is a true and correct transcript of my original stenographic notes.

I further certify that I am neither attorney or counsel, nor related to or employed by any of the parties to the action in which this deposition is taken; and furthermore, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

_____

Samara J. Zink
Notary Public in and for the
State of Maryland

My commission expires: February 28, 2017

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ACKNOWLEDGMENT OF DEPONENT

I,_____, do hereby certify that I have read the foregoing pages, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

_____

HARRY W. JOHNSON, JR., M.D. DATE

Subscribed and sworn to before me this

_____ day of _____, 20____.

My commission expires:_____

_____

Notary Public

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LAWYER'S NOTES

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